

All Savers Insurance Company: Bronze A

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$5,500 per person per calendar year. Doesn't apply to prescription drugs, services list below with copayments and "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No , there are no other specific deductibles .	You must pay all of the costs for these services up to specific deductible amount before this plan begins to pay these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$6,350 person / \$12,700 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.

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Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$50 copay per visit	Not covered	-----none-----
	Specialist visit	\$100 copay per visit	Not covered	-----none-----
	Other practitioner office visit	\$100 copay per visit	Not covered	The following are limited person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits
	Preventive care/screening/immunization	20% coinsurance	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	-----none-----

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com .	Outpatient drugs	20% <u>coinsurance</u>	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference. If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Specialty drugs	20% <u>coinsurance</u>	Not covered	-----none-----
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
If you need immediate medical attention	Emergency room services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Ambulance services covered by a local government are not covered.
	Urgent care	20% <u>coinsurance</u>	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fee	20% <u>coinsurance</u>	Not covered	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% <u>coinsurance</u>	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u>	Not covered	
	Substance use disorder outpatient services	20% <u>coinsurance</u>	Not covered	
	Substance use disorder inpatient services	20% <u>coinsurance</u>	Not covered	
If you are pregnant	Prenatal and postnatal care	20% <u>coinsurance</u>	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
				<u>deductible</u> and <u>coinsurance</u> .
	Delivery and all inpatient services	20% <u>coinsurance</u>	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	Not covered	-----none-----
	Rehabilitation services	20% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Habilitative services	20% <u>coinsurance</u>	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Skilled nursing care	20% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Durable medical equipment	20% <u>coinsurance</u>	Not covered	-----none-----
	Hospice service	20% <u>coinsurance</u>	Not covered	Limited to a prognosis of 6 months or less to live.
If your child needs dental or eye care	Eye exam	20% <u>coinsurance</u>	Not covered	Limited to one exam per calendar year.
	Glasses	20% <u>coinsurance</u>	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Dental check-up	20% <u>coinsurance</u>	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|----------------------------------|------------------------------------------------------|------------------------------------------------------------------------------|
| • Acupuncture | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Services provided by <u>non-network providers</u> , except for emergencies |
| • Dental care (adult) | • Routine eye care (adult) | • Weight-loss programs |
| • Hearing aids (age 18 and over) | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------|
| • Bariatric surgery - limitations may apply | • Infertility treatment - limitations may apply | • Private duty nursing (unless it is for home health care) |
| • Hearing aids (under age 18) | • Manipulative (Chiropractic) Services – limitations may apply | |

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (877) 855-6538. You may also contact your state insurance department at (877) 261-8807.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance.

For questions about your rights, this notice, or assistance, you can contact: Maryland Insurance Administration at (877) 261-8807.

Additionally, a consumer assistance program can help you file your appeal. Contact (877) 261-8807 or email: heau@oag.state.md.us.

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (877) 855-6538.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 855-6538.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$2,210
- Patient pays \$5,330

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$5,180
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$5,330

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$380
- Patient pays \$5,020

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$4,580
Copays	\$400
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$5,020

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Bronze HSA

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Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$6,350 per person / \$12,700 per family per calendar year. Doesn't apply to services list below "No charge"	You must pay all the costs up to the <u>deductible</u> amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the <u>deductible</u> starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on Page 2 for others costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$6,350 person / \$12,700 family per calendar year. No, Non-network	Network: The <u>out-of-pocket limit</u> is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billed</u> charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses <u>network providers</u> . If you use a non-network <u>provider</u> your cost will be more. For a list of network <u>providers</u> , see www.myuhc.com or call 1-877-855-6538 for a list of network <u>providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to <u>providers</u> in their network.
Do I need a referral to	Yes , written approval is required	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's

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see a <u>specialist</u> ?	to see a specialist.	permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	Not covered	-----none-----
	Specialist visit	0% coinsurance	Not covered	-----none-----
	Other practitioner office visit	0% coinsurance	Not covered	The following are limited person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits
	Preventive care/screening/immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	-----none-----

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If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com .	Outpatient drugs	0% coinsurance	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference. If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	-----none-----
	Physician/surgeon fees	0% coinsurance	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	-----none-----
	Emergency medical transportation	0% coinsurance	0% coinsurance	Ambulance services covered by a local government are not covered.
	Urgent care	0% coinsurance	0% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	-----none-----
	Physician/surgeon fee	0% coinsurance	Not covered	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.
	Mental/Behavioral health inpatient services	0% coinsurance	Not covered	
	Substance use disorder outpatient services	0% coinsurance	Not covered	
	Substance use disorder inpatient services	0% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .

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	Delivery and all inpatient services	0% coinsurance	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	-----none-----
	Rehabilitation services	0% coinsurance	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Habilitative services	0% coinsurance	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Skilled nursing care	0% coinsurance	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Durable medical equipment	0% coinsurance	Not covered	-----none-----
	Hospice service	0% coinsurance	Not covered	Limited to a prognosis of 6 months or less to live.
If your child needs dental or eye care	Eye exam	0% coinsurance	Not covered	Limited to one exam per calendar year.
	Glasses	0% coinsurance	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Dental check-up	0% coinsurance	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|----------------------------------|------------------------------------------------------|------------------------------------------------------------------------------|
| • Acupuncture | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Services provided by <u>non-network providers</u> , except for emergencies |
| • Dental care (adult) | • Routine eye care (adult) | • Weight-loss programs |
| • Hearing aids (age 18 and over) | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------|
| • Bariatric surgery - limitations may apply | • Infertility treatment - limitations may apply | • Private duty nursing (unless it is for home health care) |
| • Hearing aids (under age 18) | • Manipulative (Chiropractic) Services – limitations may apply | |

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (877) 855-6538. You may also contact your state insurance department at (877) 261-8807.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance.

For questions about your rights, this notice, or assistance, you can contact: Maryland Insurance Administration at (877) 261-8807.

Additionally, a consumer assistance program can help you file your appeal. Contact (877) 261-8807 or email: heau@oag.state.md.us.

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-877-855-6538 to request a copy.

All Savers Insurance Company: Bronze HSA

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (877) 855-6538.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 855-6538.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-877-855-6538 to request a copy.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$2,210
- Patient pays \$5,330

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$5,180
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$5,330

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$60
- Patient pays \$5,340

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$5,300
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$5,340

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Silver A LCS

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$2,500 per person per calendar year. Doesn't apply to prescription drugs, services list below with copayments and "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	Yes , Prescription drugs \$1,000 combined for tiers 2-4 per person. There are no other specific deductibles .	You must pay all of the costs for these services up to specific deductible amount before this plan begins to pay these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$6,350 person / \$12,700 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-877-855-6538 to request a copy.

All Savers Insurance Company: Silver A LCS

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copayment</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Specialist visit	\$70 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Other practitioner office visit	\$70 <u>copay</u> per visit	Not covered	The following are limited person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits
	Preventive care/screening/immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	-----none-----

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All Savers Insurance Company: Silver A LCS

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myuhc.com .	Outpatient Tier 1 drugs	Retail:\$15 <u>copay</u>	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 2 drugs	Retail \$40 <u>copay</u>	Not covered	The <u>prescription drug deductible</u> must be met before the <u>copayment</u> amount is applied. Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 3 drugs	Retail: \$80 <u>copay</u>	Not covered	
	Outpatient Tier 4 drugs	30% of negotiated rate	Not covered	
	Specialty drugs	30% <u>coinsurance</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fees	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
If you need immediate medical attention	Emergency room services	30% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Emergency medical transportation	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Ambulance services covered by a local government are not covered.
	Urgent care	30% <u>coinsurance</u>	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fee	30% <u>coinsurance</u>	Not covered	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% <u>coinsurance</u>	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.
	Mental/Behavioral health inpatient services	30% <u>coinsurance</u>	Not covered	
	Substance use disorder outpatient services	30% <u>coinsurance</u>	Not covered	
	Substance use disorder inpatient services	30% <u>coinsurance</u>	Not covered	
If you are pregnant	Prenatal and postnatal care	30% <u>coinsurance</u>	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive

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All Savers Insurance Company: Silver A LCS

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
				care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Delivery and all inpatient services	30% <u>coinsurance</u>	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	30% <u>coinsurance</u>	Not covered	-----none-----
	Rehabilitation services	30% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Habilitative services	30% <u>coinsurance</u>	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Skilled nursing care	30% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Durable medical equipment	30% <u>coinsurance</u>	Not covered	-----none-----
	Hospice service	30% <u>coinsurance</u>	Not covered	Limited to a prognosis of 6 months or less to live.
If your child needs dental or eye care	Eye exam	30% <u>coinsurance</u>	Not covered	Limited to one exam per calendar year.
	Glasses	30% <u>coinsurance</u>	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Dental check-up	30% <u>coinsurance</u>	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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All Savers Insurance Company: Silver A LCS

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|----------------------------------|------------------------------------------------------|------------------------------------------------------------------------------|
| • Acupuncture | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Services provided by <u>non-network providers</u> , except for emergencies |
| • Dental care (adult) | • Routine eye care (adult) | • Weight-loss programs |
| • Hearing aids (age 18 and over) | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------|
| • Bariatric surgery - limitations may apply | • Infertility treatment - limitations may apply | • Private duty nursing (unless it is for home health care) |
| • Hearing aids (under age 18) | • Manipulative (Chiropractic) Services – limitations may apply | |

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

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For more information on your rights to continue coverage, contact the insurer at (877) 855-6538. You may also contact your state insurance department at (877) 261-8807.

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Additionally, a consumer assistance program can help you file your appeal. Contact (877) 261-8807 or email: heau@oag.state.md.us.

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All Savers Insurance Company: Silver A LCS

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (877) 855-6538.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 855-6538.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$3,480
- **Patient pays** \$4,060

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$3,350
Copays	\$20
Coinsurance	\$540
Limits or exclusions	\$150
Total	\$3,350

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$2,740
- **Patient pays** \$2,660

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,740
Copays	\$880
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$2,660

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Silver A 73% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$2,500 per person per calendar year. Doesn't apply to prescription drugs, services list below with copayments and "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	Yes , Prescription drugs \$1,000 combined for tiers 2-4 per person. There are no other specific deductibles .	You must pay all of the costs for these services up to specific deductible amount before this plan begins to pay these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$4,275 person / \$8,550 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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All Savers Insurance Company: Silver A 73% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copayment</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Specialist visit	\$70 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Other practitioner office visit	\$70 <u>copay</u> per visit	Not covered	The following are limited person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits
	Preventive care/screening/immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	-----none-----

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All Savers Insurance Company: Silver A 73% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myuhc.com .	Outpatient Tier 1 drugs	Retail:\$15 <u>copay</u>	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 2 drugs	Retail \$40 <u>copay</u>	Not covered	The <u>prescription drug deductible</u> must be met before the <u>copayment</u> amount is applied. Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 3 drugs	Retail: \$80 <u>copay</u>	Not covered	
	Outpatient Tier 4 drugs	30% of negotiated rate	Not covered	
	Specialty drugs	30% <u>coinsurance</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fees	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
If you need immediate medical attention	Emergency room services	30% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Emergency medical transportation	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Ambulance services covered by a local government are not covered.
	Urgent care	30% <u>coinsurance</u>	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fee	30% <u>coinsurance</u>	Not covered	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% <u>coinsurance</u>	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.
	Mental/Behavioral health inpatient services	30% <u>coinsurance</u>	Not covered	
	Substance use disorder outpatient services	30% <u>coinsurance</u>	Not covered	
	Substance use disorder inpatient services	30% <u>coinsurance</u>	Not covered	
If you are pregnant	Prenatal and postnatal care	30% <u>coinsurance</u>	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive

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Coverage for: Individual | **Plan Type:** EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
				care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Delivery and all inpatient services	30% <u>coinsurance</u>	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	30% <u>coinsurance</u>	Not covered	-----none-----
	Rehabilitation services	30% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Habilitative services	30% <u>coinsurance</u>	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Skilled nursing care	30% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Durable medical equipment	30% <u>coinsurance</u>	Not covered	-----none-----
	Hospice service	30% <u>coinsurance</u>	Not covered	Limited to a prognosis of 6 months or less to live.
If your child needs dental or eye care	Eye exam	30% <u>coinsurance</u>	Not covered	Limited to one exam per calendar year.
	Glasses	30% <u>coinsurance</u>	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Dental check-up	30% <u>coinsurance</u>	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|----------------------------------|------------------------------------------------------|------------------------------------------------------------------------------|
| • Acupuncture | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Services provided by <u>non-network providers</u> , except for emergencies |
| • Dental care (adult) | • Routine eye care (adult) | • Weight-loss programs |
| • Hearing aids (age 18 and over) | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------|
| • Bariatric surgery - limitations may apply | • Infertility treatment - limitations may apply | • Private duty nursing (unless it is for home health care) |
| • Hearing aids (under age 18) | • Manipulative (Chiropractic) Services – limitations may apply | |

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (877) 855-6538. You may also contact your state insurance department at (877) 261-8807.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance.

For questions about your rights, this notice, or assistance, you can contact: Maryland Insurance Administration at (877) 261-8807.

Additionally, a consumer assistance program can help you file your appeal. Contact (877) 261-8807 or email: heau@oag.state.md.us.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (877) 855-6538.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 855-6538.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$3,480
- **Patient pays** \$4,060

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$3,350
Copays	\$20
Coinsurance	\$540
Limits or exclusions	\$150
Total	\$3,350

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$2,740
- **Patient pays** \$2,660

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,740
Copays	\$880
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$2,660

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Silver A 87% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$1,000 per person per calendar year. Doesn't apply to prescription drugs, services list below with copayments and "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	Yes , Prescription drugs \$150 combined for tiers 2-4 per person. There are no other specific deductibles .	You must pay all of the costs for these services up to specific deductible amount before this plan begins to pay these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$1,200 person / \$2,440 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

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Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
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If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copayment</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Specialist visit	\$70 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Other practitioner office visit	\$70 <u>copay</u> per visit	Not covered	The following are limited person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits
	Preventive care/screening/immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	-----none-----

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myuhc.com .	Outpatient Tier 1 drugs	Retail:\$15 <u>copay</u>	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 2 drugs	Retail \$40 <u>copay</u>	Not covered	The <u>prescription drug deductible</u> must be met before the <u>copayment</u> amount is applied. Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 3 drugs	Retail: \$80 <u>copay</u>	Not covered	
	Outpatient Tier 4 drugs	30% of negotiated rate	Not covered	
	Specialty drugs	30% <u>coinsurance</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fees	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
If you need immediate medical attention	Emergency room services	30% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Emergency medical transportation	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Ambulance services covered by a local government are not covered.
	Urgent care	30% <u>coinsurance</u>	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fee	30% <u>coinsurance</u>	Not covered	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% <u>coinsurance</u>	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.
	Mental/Behavioral health inpatient services	30% <u>coinsurance</u>	Not covered	
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	Substance use disorder inpatient services	30% <u>coinsurance</u>	Not covered	
If you are pregnant	Prenatal and postnatal care	30% <u>coinsurance</u>	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive

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				care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Delivery and all inpatient services	30% <u>coinsurance</u>	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	30% <u>coinsurance</u>	Not covered	-----none-----
	Rehabilitation services	30% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
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	Glasses	30% <u>coinsurance</u>	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
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Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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- Long-term care
- Routine foot care
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Services provided by non-network providers, except for emergencies
- Dental care (adult)
- Routine eye care (adult)
- Weight-loss programs
- Hearing aids (age 18 and over)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery - limitations may apply
- Infertility treatment - limitations may apply
- Private duty nursing (unless it is for home health care)
- Hearing aids (under age 18)
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All Savers Insurance Company: Silver A 87% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | **Plan Type:** EPO

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (877) 855-6538.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 855-6538.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-877-855-6538 to request a copy.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$4,530
- **Patient pays** \$3,010

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,850
Copays	\$20
Coinsurance	\$990
Limits or exclusions	\$150
Total	\$3,010

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$3,260
- **Patient pays** \$2,140

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,00
Copays	\$880
Coinsurance	\$220
Limits or exclusions	\$40
Total	\$2,140

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Silver A 94% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$350 per person per calendar year. Doesn't apply to prescription drugs, services list below with copayments and "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	Yes , Prescription drugs \$50 combined for tiers 2-4 per person. There are no other specific deductibles .	You must pay all of the costs for these services up to specific deductible amount before this plan begins to pay these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$500 person / \$1,000 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.

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All Savers Insurance Company: Silver A 94% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copayment</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Specialist visit	\$70 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Other practitioner office visit	\$70 <u>copay</u> per visit	Not covered	The following are limited person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits
	Preventive care/screening/immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	-----none-----

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All Savers Insurance Company: Silver A 94% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myuhc.com .	Outpatient Tier 1 drugs	Retail:\$15 <u>copay</u>	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 2 drugs	Retail \$40 <u>copay</u>	Not covered	The prescription drug deductible must be met before the copayment amount is applied. Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 3 drugs	Retail: \$80 <u>copay</u>	Not covered	
	Outpatient Tier 4 drugs	30% of negotiated rate	Not covered	
	Specialty drugs	30% <u>coinsurance</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fees	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
If you need immediate medical attention	Emergency room services	30% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Emergency medical transportation	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Ambulance services covered by a local government are not covered.
	Urgent care	30% <u>coinsurance</u>	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fee	30% <u>coinsurance</u>	Not covered	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% <u>coinsurance</u>	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.
	Mental/Behavioral health inpatient services	30% <u>coinsurance</u>	Not covered	
	Substance use disorder outpatient services	30% <u>coinsurance</u>	Not covered	
	Substance use disorder inpatient services	30% <u>coinsurance</u>	Not covered	
If you are pregnant	Prenatal and postnatal care	30% <u>coinsurance</u>	Not covered	Complications of pregnancy are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
				care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Delivery and all inpatient services	30% <u>coinsurance</u>	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	30% <u>coinsurance</u>	Not covered	-----none-----
	Rehabilitation services	30% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Habilitative services	30% <u>coinsurance</u>	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Skilled nursing care	30% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Durable medical equipment	30% <u>coinsurance</u>	Not covered	-----none-----
	Hospice service	30% <u>coinsurance</u>	Not covered	Limited to a prognosis of 6 months or less to live.
If your child needs dental or eye care	Eye exam	30% <u>coinsurance</u>	Not covered	Limited to one exam per calendar year.
	Glasses	30% <u>coinsurance</u>	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Dental check-up	30% <u>coinsurance</u>	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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All Savers Insurance Company: Silver A 94% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|----------------------------------|------------------------------------------------------|------------------------------------------------------------------------------|
| • Acupuncture | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Services provided by <u>non-network providers</u> , except for emergencies |
| • Dental care (adult) | • Routine eye care (adult) | • Weight-loss programs |
| • Hearing aids (age 18 and over) | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------|
| • Bariatric surgery - limitations may apply | • Infertility treatment - limitations may apply | • Private duty nursing (unless it is for home health care) |
| • Hearing aids (under age 18) | • Manipulative (Chiropractic) Services – limitations may apply | |

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (877) 855-6538. You may also contact your state insurance department at (877) 261-8807.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance.

For questions about your rights, this notice, or assistance, you can contact: Maryland Insurance Administration at (877) 261-8807.

Additionally, a consumer assistance program can help you file your appeal. Contact (877) 261-8807 or email: heau@oag.state.md.us.

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All Savers Insurance Company: Silver A 94% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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Coverage for: Individual | **Plan Type:** EPO

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
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estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$6,390
- **Patient pays** \$1,150

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$700
Copays	\$0
Coinsurance	\$300
Limits or exclusions	\$150
Total	\$1,150

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,860
- **Patient pays** \$540

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$350
Copays	\$110
Coinsurance	\$40
Limits or exclusions	\$40
Total	\$540

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

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- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Silver B

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$3,500 per person per calendar year. Doesn't apply to prescription drugs, services list below with copayments and "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	Yes , Prescription drugs \$1,000 combined for tiers 2-4 per person. There are no other specific deductibles .	You must pay all of the costs for these services up to specific deductible amount before this plan begins to pay these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$6,350 person / \$12,700 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.

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All Savers Insurance Company: Silver B

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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Coverage for: Individual | Plan Type: EPO

Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copayment</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Specialist visit	\$70 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Other practitioner office visit	\$70 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply. The following are limited per person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits.
	Preventive care/screening/immunization	No charge	Not covered	Includes preventive health services specified

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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All Savers Insurance Company: Silver B

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | **Plan Type:** EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
				in the health care reform law. No coverage for non-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com .	Outpatient Tier 1 drugs	Retail:\$12 <u>copay</u>	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 2 drugs	Retail \$40 <u>copay</u>	Not covered	The <u>prescription drug deductible</u> must be met before the <u>copayment</u> amount is applied. Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 3 drugs	Retail: \$80 <u>copay</u>	Not covered	
	Outpatient Tier 4 drugs	25% of negotiated rate	Not covered	
	Specialty drugs	20% <u>coinsurance</u>	Not covered	-----none-----
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	Emergency room services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Ambulance services covered by a local government are not covered.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	Urgent care	20% <u>coinsurance</u>	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fee	20% <u>coinsurance</u>	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.

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Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% <u>coinsurance</u>	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u>	Not covered	
	Substance use disorder outpatient services	20% <u>coinsurance</u>	Not covered	
	Substance use disorder inpatient services	20% <u>coinsurance</u>	Not covered	
If you are pregnant	Prenatal and postnatal care	20% <u>coinsurance</u>	Not covered	-----none-----
	Delivery and all inpatient services	20% <u>coinsurance</u>	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Rehabilitation services	20% <u>coinsurance</u>	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Habilitative services	20% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Skilled nursing care	20% <u>coinsurance</u>	Not covered	-----none-----
	Durable medical equipment	20% <u>coinsurance</u>	Not covered	Limited to a prognosis of 6 months or less to live.
	Hospice service	20% <u>coinsurance</u>	Not covered	Limited to one exam per calendar year.
If your child needs dental or eye care	Eye exam	20% <u>coinsurance</u>	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Glasses	20% <u>coinsurance</u>	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
	Dental check-up	20% <u>coinsurance</u>	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids (age 18 and over)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care
- Services provided by non-network providers, except for emergencies
- Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery - limitations may apply
- Hearing aids (under age 18)
- Infertility treatment - limitations may apply
- Manipulative (Chiropractic) Services – limitations may apply
- Private duty nursing (unless it is for home health care)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (877) 855-6538. You may also contact your state insurance department at (877) 261-8807.

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For questions about your rights, this notice, or assistance, you can contact: Maryland Insurance Administration at (877) 261-8807.

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (877) 855-6538.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 855-6538.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$2,860
- **Patient pays** \$4,680

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$4,350
Copays	\$20
Coinsurance	\$160
Limits or exclusions	\$150
Total	\$4,680

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$2,860
- **Patient pays** \$ 2,540

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,740
Copays	\$760
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$2,540

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Silver B 73% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$3,500 per person per calendar year. Doesn't apply to prescription drugs, services list below with copayments and "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	Yes , Prescription drugs \$500 combined for tiers 2-4 per person. There are no other specific deductibles .	You must pay all of the costs for these services up to specific deductible amount before this plan begins to pay these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$4,400 person / \$8,800 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.

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Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copayment</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Specialist visit	\$70 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Other practitioner office visit	\$70 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply. The following are limited per person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits.
	Preventive care/screening/immunization	No charge	Not covered	Includes preventive health services specified

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
				in the health care reform law. No coverage for non-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com .	Outpatient Tier 1 drugs	Retail:\$12 <u>copay</u>	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 2 drugs	Retail \$40 <u>copay</u>	Not covered	The <u>prescription drug deductible</u> must be met before the <u>copayment</u> amount is applied. Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 3 drugs	Retail: \$80 <u>copay</u>	Not covered	
	Outpatient Tier 4 drugs	25% of negotiated rate	Not covered	
	Specialty drugs	20% <u>coinsurance</u>	Not covered	-----none-----
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	Emergency room services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Ambulance services covered by a local government are not covered.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	Urgent care	20% <u>coinsurance</u>	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fee	20% <u>coinsurance</u>	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% <u>coinsurance</u>	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u>	Not covered	
	Substance use disorder outpatient services	20% <u>coinsurance</u>	Not covered	
	Substance use disorder inpatient services	20% <u>coinsurance</u>	Not covered	
If you are pregnant	Prenatal and postnatal care	20% <u>coinsurance</u>	Not covered	-----none-----
	Delivery and all inpatient services	20% <u>coinsurance</u>	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Rehabilitation services	20% <u>coinsurance</u>	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
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	Hospice service	20% <u>coinsurance</u>	Not covered	Limited to one exam per calendar year.
If your child needs dental or eye care	Eye exam	20% <u>coinsurance</u>	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
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Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$2,860
- **Patient pays** \$4,680

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$4,350
Copays	\$20
Coinsurance	\$160
Limits or exclusions	\$150
Total	\$4,680

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$2,860
- **Patient pays** \$ 2,540

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,740
Copays	\$760
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$2,540

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Silver B 87% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$1,000 per person per calendar year. Doesn't apply to prescription drugs, services list below with copayments and "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	Yes , Prescription drugs \$250 combined for tiers 2-4 per person. There are no other specific deductibles .	You must pay all of the costs for these services up to specific deductible amount before this plan begins to pay these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$1,300 person / \$2,600 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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All Savers Insurance Company: Silver B 87% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copayment</u> per visit	Not covered	If you receive services in addition to office visit, additional copayments , deductible or coinsurance may apply.
	Specialist visit	\$70 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional copayments , deductible or coinsurance may apply.
	Other practitioner office visit	\$70 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional copayments , deductible or coinsurance may apply. The following are limited per person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits.
	Preventive care/screening/immunization	No charge	Not covered	Includes preventive health services specified

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
				in the health care reform law. No coverage for non-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com .	Outpatient Tier 1 drugs	Retail:\$12 <u>copay</u>	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 2 drugs	Retail \$40 <u>copay</u>	Not covered	The <u>prescription drug deductible</u> must be met before the <u>copayment</u> amount is applied. Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 3 drugs	Retail: \$80 <u>copay</u>	Not covered	
	Outpatient Tier 4 drugs	25% of negotiated rate	Not covered	
	Specialty drugs	20% <u>coinsurance</u>	Not covered	-----none-----
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	Emergency room services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Ambulance services covered by a local government are not covered.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	Urgent care	20% <u>coinsurance</u>	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fee	20% <u>coinsurance</u>	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% <u>coinsurance</u>	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u>	Not covered	
	Substance use disorder outpatient services	20% <u>coinsurance</u>	Not covered	
	Substance use disorder inpatient services	20% <u>coinsurance</u>	Not covered	
If you are pregnant	Prenatal and postnatal care	20% <u>coinsurance</u>	Not covered	-----none-----
	Delivery and all inpatient services	20% <u>coinsurance</u>	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Rehabilitation services	20% <u>coinsurance</u>	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Habilitative services	20% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Skilled nursing care	20% <u>coinsurance</u>	Not covered	-----none-----
	Durable medical equipment	20% <u>coinsurance</u>	Not covered	Limited to a prognosis of 6 months or less to live.
	Hospice service	20% <u>coinsurance</u>	Not covered	Limited to one exam per calendar year.
If your child needs dental or eye care	Eye exam	20% <u>coinsurance</u>	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Glasses	20% <u>coinsurance</u>	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
	Dental check-up	20% <u>coinsurance</u>	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids (age 18 and over)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care
- Services provided by non-network providers, except for emergencies
- Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery - limitations may apply
- Hearing aids (under age 18)
- Infertility treatment - limitations may apply
- Manipulative (Chiropractic) Services – limitations may apply
- Private duty nursing (unless it is for home health care)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (877) 855-6538. You may also contact your state insurance department at (877) 261-8807.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance.

For questions about your rights, this notice, or assistance, you can contact: Maryland Insurance Administration at (877) 261-8807.

Additionally, a consumer assistance program can help you file your appeal. Contact (877) 261-8807 or email: heau@oag.state.md.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

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—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$4,860
- **Patient pays** \$2,680

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,850
Copays	\$20
Coinsurance	\$660
Limits or exclusions	\$150
Total	\$2,680

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$3,450
- **Patient pays** \$1,950

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,000
Copays	\$760
Coinsurance	\$150
Limits or exclusions	\$40
Total	\$1,950

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

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- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Silver B 94% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO



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Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$350 per person per calendar year. Doesn't apply to prescription drugs, services list below with copayments and "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	Yes , Prescription drugs \$50 combined for tiers 2-4 per person. There are no other specific deductibles .	You must pay all of the costs for these services up to specific deductible amount before this plan begins to pay these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$500 person / \$1,000 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copayment</u> per visit	Not covered	If you receive services in addition to office visit, additional copayments , deductible or coinsurance may apply.
	Specialist visit	\$70 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional copayments , deductible or coinsurance may apply.
	Other practitioner office visit	\$70 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional copayments , deductible or coinsurance may apply. The following are limited per person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits.
	Preventive care/screening/immunization	No charge	Not covered	Includes preventive health services specified

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All Savers Insurance Company: Silver B 94% AV

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
				in the health care reform law. No coverage for non-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myuhc.com .	Outpatient Tier 1 drugs	Retail:\$12 <u>copay</u>	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 2 drugs	Retail \$40 <u>copay</u>	Not covered	The <u>prescription drug deductible</u> must be met before the <u>copayment</u> amount is applied. Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 3 drugs	Retail: \$80 <u>copay</u>	Not covered	
	Outpatient Tier 4 drugs	25% of negotiated rate	Not covered	
	Specialty drugs	20% <u>coinsurance</u>	Not covered	-----none-----
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	Emergency room services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Ambulance services covered by a local government are not covered.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	Urgent care	20% <u>coinsurance</u>	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fee	20% <u>coinsurance</u>	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% <u>coinsurance</u>	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u>	Not covered	
	Substance use disorder outpatient services	20% <u>coinsurance</u>	Not covered	
	Substance use disorder inpatient services	20% <u>coinsurance</u>	Not covered	
If you are pregnant	Prenatal and postnatal care	20% <u>coinsurance</u>	Not covered	-----none-----
	Delivery and all inpatient services	20% <u>coinsurance</u>	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Rehabilitation services	20% <u>coinsurance</u>	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Habilitative services	20% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Skilled nursing care	20% <u>coinsurance</u>	Not covered	-----none-----
	Durable medical equipment	20% <u>coinsurance</u>	Not covered	Limited to a prognosis of 6 months or less to live.
	Hospice service	20% <u>coinsurance</u>	Not covered	Limited to one exam per calendar year.
If your child needs dental or eye care	Eye exam	20% <u>coinsurance</u>	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Glasses	20% <u>coinsurance</u>	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
	Dental check-up	20% <u>coinsurance</u>	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids (age 18 and over)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care
- Services provided by non-network providers, except for emergencies
- Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery - limitations may apply
- Hearing aids (under age 18)
- Infertility treatment - limitations may apply
- Manipulative (Chiropractic) Services – limitations may apply
- Private duty nursing (unless it is for home health care)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (877) 855-6538. You may also contact your state insurance department at (877) 261-8807.

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance.

For questions about your rights, this notice, or assistance, you can contact: Maryland Insurance Administration at (877) 261-8807.

Additionally, a consumer assistance program can help you file your appeal. Contact (877) 261-8807 or email: heau@oag.state.md.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (877) 855-6538.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 855-6538.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$6,440
- **Patient pays** \$1,100

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$700
Copays	\$0
Coinsurance	\$250
Limits or exclusions	\$150
Total	\$1,100

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,865
- **Patient pays** \$535

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$350
Copays	\$125
Coinsurance	\$20
Limits or exclusions	\$40
Total	\$535

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Silver HSA

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$3,650 per person / \$7,300 per family per calendar year. Doesn't apply to services list below "No charge"	You must pay all the costs up to the <u>deductible</u> amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the <u>deductible</u> starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes , Prescription drugs \$500 combined for tiers 2-4 per person. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to specific <u>deductible</u> amount before this plan begins to pay these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$3,650 person / \$7,300 family per calendar year. No, Non-network	Network: The <u>out-of-pocket limit</u> is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billed</u> charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses <u>network providers</u> . If you use a non-network <u>provider</u> your cost will be more. For a list of network <u>providers</u> , see www.myuhc.com or call 1-877-855-6538 for a list of network <u>providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to <u>providers</u> in their network.

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All Savers Insurance Company: Silver HSA

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	Not covered	-----none-----
	Specialist visit	0% coinsurance	Not covered	-----none-----
	Other practitioner office visit	0% coinsurance	Not covered	The following are limited person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits
	Preventive care/screening/immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	-----none-----

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com .	Outpatient drugs	0% coinsurance	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference. If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Specialty drugs	0% coinsurance	Not covered	-----none-----
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
	Physician/surgeon fees	0% coinsurance	Not covered	-----none-----
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	Ambulance services covered by a local government are not covered.
	Emergency medical transportation	0% coinsurance	0% coinsurance	-----none-----
	Urgent care	0% coinsurance	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	-----none-----
	Physician/surgeon fee	0% coinsurance	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Mental/Behavioral health inpatient services	0% coinsurance	Not covered	
	Substance use disorder outpatient services	0% coinsurance	Not covered	
	Substance use disorder inpatient services	0% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not covered	-----none-----
	Delivery and all inpatient services	0% coinsurance	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Rehabilitation services	0% coinsurance	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Habilitative services	0% coinsurance	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Skilled nursing care	0% coinsurance	Not covered	-----none-----
	Durable medical equipment	0% coinsurance	Not covered	Limited to a prognosis of 6 months or less to live.
	Hospice service	0% coinsurance	Not covered	Limited to one exam per calendar year.
If your child needs dental or eye care	Eye exam	0% coinsurance	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Glasses	0% coinsurance	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
	Dental check-up		Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids (age 18 and over)
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- Bariatric surgery - limitations may apply
- Hearing aids (under age 18)
- Infertility treatment - limitations may apply
- Manipulative (Chiropractic) Services – limitations may apply
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Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

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Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$2,890
- Patient pays \$ 4,650

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$4,500
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$4,650

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$1,710
- Patient pays \$3,690

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$3,650
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$3,690

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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R1

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Silver HSA 73% AV

Coverage Period: Beginning on or after 1/1/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	Network: \$2,900 per person / \$5,800 per family per calendar year. Doesn't apply to services list below "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on Page 2 for others costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: \$2,900 person / \$5,800 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to	Yes , written approval is required	This plan will pay some or all of the costs to see a specialist but only if you have the plan's

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: EPO

see a <u>specialist</u> ?	to see a specialist.	permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	Not covered	-----none-----
	Specialist visit	0% coinsurance	Not covered	-----none-----
	Other practitioner office visit	0% coinsurance	Not covered	The following are limited person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits
	Preventive care/screening/immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	-----none-----

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com .	Outpatient drugs	0% coinsurance	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference. If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Specialty drugs	0% coinsurance	Not covered	-----none-----
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
	Physician/surgeon fees	0% coinsurance	Not covered	-----none-----
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	Ambulance services covered by a local government are not covered.
	Emergency medical transportation	0% coinsurance	0% coinsurance	-----none-----
	Urgent care	0% coinsurance	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	-----none-----
	Physician/surgeon fee	0% coinsurance	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Mental/Behavioral health inpatient services	0% coinsurance	Not covered	
	Substance use disorder outpatient services	0% coinsurance	Not covered	
	Substance use disorder inpatient services	0% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not covered	-----none-----
	Delivery and all inpatient services	0% coinsurance	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Rehabilitation services	0% coinsurance	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Habilitative services	0% coinsurance	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Skilled nursing care	0% coinsurance	Not covered	-----none-----
	Durable medical equipment	0% coinsurance	Not covered	Limited to a prognosis of 6 months or less to live.
	Hospice service	0% coinsurance	Not covered	Limited to one exam per calendar year.
If your child needs dental or eye care	Eye exam	0% coinsurance	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Glasses	0% coinsurance	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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All Savers Insurance Company: Silver HSA 73% AV

Coverage Period: Beginning on or after 1/1/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
	Dental check-up		Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids (age 18 and over)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care
- Services provided by non-network providers, except for emergencies
- Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery - limitations may apply
- Hearing aids (under age 18)
- Infertility treatment - limitations may apply
- Manipulative (Chiropractic) Services – limitations may apply
- Private duty nursing (unless it is for home health care)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (877) 855-6538. You may also contact your state insurance department at (877) 261-8807.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance.

For questions about your rights, this notice, or assistance, you can contact: Maryland Insurance Administration at (877) 261-8807.

Additionally, a consumer assistance program can help you file your appeal. Contact (877) 261-8807 or email: heau@oag.state.md.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (877) 855-6538.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 855-6538.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$3,640
- **Patient pays** \$3,900

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$3,750
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$,3900

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$2,640
- **Patient pays** \$2,940

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,900
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$2,940

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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R1

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Silver HSA 87% AV Coverage Period: Beginning on or after 1/1/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: EPO



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Important Questions	Answers	Why this Matters:
What is the overall deductible ?	Network: \$1,100 per person / \$2,200 per family per calendar year. Doesn't apply to services list below "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on Page 2 for others costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: \$1,100 person / \$2,200 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to	Yes , written approval is required	This plan will pay some or all of the costs to see a specialist but only if you have the plan's

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see a <u>specialist</u> ?	to see a specialist.	permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	Not covered	-----none-----
	Specialist visit	0% coinsurance	Not covered	-----none-----
	Other practitioner office visit	0% coinsurance	Not covered	The following are limited person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits
	Preventive care/screening/immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	-----none-----

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com .	Outpatient drugs	0% coinsurance	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference. If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Specialty drugs	0% coinsurance	Not covered	-----none-----
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
	Physician/surgeon fees	0% coinsurance	Not covered	-----none-----
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	Ambulance services covered by a local government are not covered.
	Emergency medical transportation	0% coinsurance	0% coinsurance	-----none-----
	Urgent care	0% coinsurance	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	-----none-----
	Physician/surgeon fee	0% coinsurance	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Mental/Behavioral health inpatient services	0% coinsurance	Not covered	
	Substance use disorder outpatient services	0% coinsurance	Not covered	
	Substance use disorder inpatient services	0% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not covered	-----none-----
	Delivery and all inpatient services	0% coinsurance	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Rehabilitation services	0% coinsurance	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Habilitative services	0% coinsurance	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Skilled nursing care	0% coinsurance	Not covered	-----none-----
	Durable medical equipment	0% coinsurance	Not covered	Limited to a prognosis of 6 months or less to live.
	Hospice service	0% coinsurance	Not covered	Limited to one exam per calendar year.
If your child needs dental or eye care	Eye exam	0% coinsurance	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Glasses	0% coinsurance	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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All Savers Insurance Company: Silver HSA 87% AV

Coverage Period: Beginning on or after 1/1/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
	Dental check-up		Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids (age 18 and over)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care
- Services provided by non-network providers, except for emergencies
- Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery - limitations may apply
- Hearing aids (under age 18)
- Infertility treatment - limitations may apply
- Manipulative (Chiropractic) Services – limitations may apply
- Private duty nursing (unless it is for home health care)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (877) 855-6538. You may also contact your state insurance department at (877) 261-8807.

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance.

For questions about your rights, this notice, or assistance, you can contact: Maryland Insurance Administration at (877) 261-8807.

Additionally, a consumer assistance program can help you file your appeal. Contact (877) 261-8807 or email: heau@oag.state.md.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (877) 855-6538.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 855-6538.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$5,440
- **Patient pays** \$2,100

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,950
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$2,100

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,260
- **Patient pays** \$1,140

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,100
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,140

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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R1

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Silver HSA 94% AV

Coverage Period: Beginning on or after 1/1/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	Network: \$500 per person / \$1,000 per family per calendar year. Doesn't apply to services list below "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on Page 2 for others costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: \$500 person / \$1,000 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to	Yes , written approval is required	This plan will pay some or all of the costs to see a specialist but only if you have the plan's

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All Savers Insurance Company: Silver HSA 94% AV Coverage Period: Beginning on or after 1/1/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: EPO

see a <u>specialist</u> ?	to see a specialist.	permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	Not covered	-----none-----
	Specialist visit	0% coinsurance	Not covered	-----none-----
	Other practitioner office visit	0% coinsurance	Not covered	The following are limited person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits
	Preventive care/screening/immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	-----none-----

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All Savers Insurance Company: Silver HSA 94% AV

Coverage Period: Beginning on or after 1/1/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com .	Outpatient drugs	0% coinsurance	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference. If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Specialty drugs	0% coinsurance	Not covered	-----none-----
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
	Physician/surgeon fees	0% coinsurance	Not covered	-----none-----
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	Ambulance services covered by a local government are not covered.
	Emergency medical transportation	0% coinsurance	0% coinsurance	-----none-----
	Urgent care	0% coinsurance	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	-----none-----
	Physician/surgeon fee	0% coinsurance	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Mental/Behavioral health inpatient services	0% coinsurance	Not covered	
	Substance use disorder outpatient services	0% coinsurance	Not covered	
	Substance use disorder inpatient services	0% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not covered	-----none-----
	Delivery and all inpatient services	0% coinsurance	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Rehabilitation services	0% coinsurance	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Habilitative services	0% coinsurance	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Skilled nursing care	0% coinsurance	Not covered	-----none-----
	Durable medical equipment	0% coinsurance	Not covered	Limited to a prognosis of 6 months or less to live.
	Hospice service	0% coinsurance	Not covered	Limited to one exam per calendar year.
If your child needs dental or eye care	Eye exam	0% coinsurance	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Glasses	0% coinsurance	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
	Dental check-up		Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids (age 18 and over)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care
- Services provided by non-network providers, except for emergencies
- Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery - limitations may apply
- Hearing aids (under age 18)
- Infertility treatment - limitations may apply
- Manipulative (Chiropractic) Services – limitations may apply
- Private duty nursing (unless it is for home health care)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

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Does this Coverage Provide Minimum Essential Coverage?

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Language Access Services:

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



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Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$6,390
- **Patient pays** \$1,150

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,000
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$1,150

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,860
- **Patient pays** \$540

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$500
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$540

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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R1

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Gold A

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$1,500 per person per calendar year. Doesn't apply to prescription drugs, services list below with copayments and "No charge"	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	Yes , Prescription drugs \$500 combined for tiers 2-4 per person. There are no other specific deductibles .	You must pay all of the costs for these services up to specific deductible amount before this plan begins to pay these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$6,350 person / \$12,700 family per calendar year. No, Non-network	Network: The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses network providers . If you use a non-network provider your cost will be more. For a list of network providers , see www.myuhc.com or call 1-877-855-6538 for a list of network providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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All Savers Insurance Company: Gold A

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

Coverage for: Individual | Plan Type: EPO

Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copayment</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Specialist visit	\$30 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
	Other practitioner office visit	\$30 <u>copay</u> per visit	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply. The following are limited per person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits.
	Preventive care/screening/immunization	No charge	Not covered	Includes preventive health services specified

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
				in the health care reform law. No coverage for non-network.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com	Outpatient Tier 1 drugs	Retail:\$12 <u>copay</u>	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 2 drugs	Retail \$35 <u>copay</u>	Not covered	The <u>prescription drug deductible</u> must be met before the <u>copayment</u> amount is applied. Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 3 drugs	Retail: \$65 <u>copay</u>	Not covered	
	Outpatient Tier 4 drugs	25% of negotiated rate	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
If you need immediate medical attention	Emergency room services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	-----none-----
	Emergency medical transportation	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Ambulance services covered by a local government are not covered.
	Urgent care	10% <u>coinsurance</u>	10% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not covered	-----none-----
	Physician/surgeon fee	10% <u>coinsurance</u>	Not covered	-----none-----

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% <u>coinsurance</u>	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.
	Mental/Behavioral health inpatient services	10% <u>coinsurance</u>	Not covered	
	Substance use disorder outpatient services	10% <u>coinsurance</u>	Not covered	
	Substance use disorder inpatient services	10% <u>coinsurance</u>	Not covered	
If you are pregnant	Prenatal and postnatal care	10% <u>coinsurance</u>	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .
	Delivery and all inpatient services	10% <u>coinsurance</u>	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	10% <u>coinsurance</u>	Not covered	-----none-----
	Rehabilitation services	10% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Habilitative services	10% <u>coinsurance</u>	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Skilled nursing care	10% <u>coinsurance</u>	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Durable medical equipment	10% <u>coinsurance</u>	Not covered	-----none-----
	Hospice service	10% <u>coinsurance</u>	Not covered	Limited to a prognosis of 6 months or less to live.
If your child needs dental or eye care	Eye exam	10% <u>coinsurance</u>	Not covered	Limited to one exam per calendar year.
	Glasses	10% <u>coinsurance</u>	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
				calendar year.
	Dental check-up	10% <u>coinsurance</u>	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids (age 18 and over)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care
- Services provided by non-network providers, except for emergencies
- Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery - limitations may apply
- Hearing aids (under age 18)
- Infertility treatment - limitations may apply
- Manipulative (Chiropractic) Services – limitations may apply
- Private duty nursing (unless it is for home health care)

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2014

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Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (877) 855-6538. You may also contact your state insurance department at (877) 261-8807.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**.

For questions about your rights, this notice, or assistance, you can contact: Maryland Insurance Administration at (877) 261-8807.

Additionally, a consumer assistance program can help you file your appeal. Contact (877) 261-8807 or email: heau@oag.state.md.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (877) 855-6538.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 855-6538.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$4,740
- **Patient pays** \$2,800

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$2,350
Copays	\$20
Coinsurance	\$280
Limits or exclusions	\$150
Total	\$2,800

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$3,240
- **Patient pays** \$2,160

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,500
Copays	\$600
Coinsurance	\$20
Limits or exclusions	\$40
Total	\$2,160

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

All Savers Insurance Company: Catastrophic

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-855-6538.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: \$6,350 per person \$12,700 per family per calendar year. Doesn't apply to services list below "No charge"	You must pay all the costs up to the <u>deductible</u> amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the <u>deductible</u> starts over (usually, but not always January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes , Prescription drugs \$500 combined for tiers 2-4 per person. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to specific <u>deductible</u> amount before this plan begins to pay these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, Network: \$6,350 person / \$12,700 family per calendar year. No, Non-network	Network: The <u>out-of-pocket limit</u> is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Non-network: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billed</u> charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No , this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes , this plan uses <u>network providers</u> . If you use a non-network <u>provider</u> your cost will be more. For a list of network <u>providers</u> , see www.myuhc.com or call 1-877-855-6538 for a list of network <u>providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to <u>providers</u> in their network.

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Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> but only if you have the plan's permission before you see the <u>specialist</u> for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	Not covered	-----none-----
	Specialist visit	0% coinsurance	Not covered	-----none-----
	Other practitioner office visit	0% coinsurance	Not covered	The following are limited person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits
	Preventive care/screening/immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	-----none-----

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Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.myuhc.com.</p>	Outpatient drugs	0% coinsurance	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference. If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductible</u> or <u>coinsurance</u> may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	-----none-----
	Physician/surgeon fees	0% coinsurance	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	-----none-----
	Emergency medical transportation	0% coinsurance	0% coinsurance	Ambulance services covered by a local government are not covered.
	Urgent care	0% coinsurance	0% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	-----none-----
	Physician/surgeon fee	0% coinsurance	Not covered	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.
	Mental/Behavioral health inpatient services	0% coinsurance	Not covered	
	Substance use disorder outpatient services	0% coinsurance	Not covered	
	Substance use disorder inpatient services	0% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	<u>Complications of pregnancy</u> are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to <u>deductible</u> and <u>coinsurance</u> .

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	Delivery and all inpatient services	0% coinsurance	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	-----none-----
	Rehabilitation services	0% coinsurance	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Habilitative services	0% coinsurance	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Skilled nursing care	0% coinsurance	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Durable medical equipment	0% coinsurance	Not covered	-----none-----
	Hospice service	0% coinsurance	Not covered	Limited to a prognosis of 6 months or less to live.
If your child needs dental or eye care	Eye exam	0% coinsurance	Not covered	Limited to one exam per calendar year.
	Glasses	0% coinsurance	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Dental check-up	0% coinsurance	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 2 per calendar year.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|----------------------------------|------------------------------------------------------|------------------------------------------------------------------------------|
| • Acupuncture | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Services provided by <u>non-network providers</u> , except for emergencies |
| • Dental care (adult) | • Routine eye care (adult) | • Weight-loss programs |
| • Hearing aids (age 18 and over) | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------|
| • Bariatric surgery - limitations may apply | • Infertility treatment - limitations may apply | • Private duty nursing (unless it is for home health care) |
| • Hearing aids (under age 18) | • Manipulative (Chiropractic) Services – limitations may apply | |

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

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Spanish (Español): Para obtener asistencia en Español, llame al (877) 855-6538.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 855-6538.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(877) 855-6538.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne'(877) 855-6538.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

Questions: Call 1-877-855-6538 or visit us at www.myuhc.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-877-855-6538 to request a copy.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$2,210
- Patient pays \$5,330

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$5,180
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$5,330

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$50
- Patient pays \$5,350

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$5,310
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$5,350

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.